TELEHEALTH TASK FORCE (TTF) MEETING AGENDA

Virtual Meeting Information

Join Zoom Meeting:
https://jubengineers.zoom.us/j/96539672373?pwd=WnV1SDhETzd6ZnNVeFI0ZVNmSStmQT09
Meeting ID: 965 3967 2373 Password: Telehealth
Phone audio: 1-669-900-6833, Meeting ID: 96539672373#

Wednesday, April 29, 2020, 9:00 AM-12 NOON MST

TIME	AGENDA ITEM	*OBJECTIVE*
9:00 a.m.	**Welcome & Introductions – Craig Belcher, Co-Chair** ☐ Welcome, Introductions, Roll Call ☐ Review meeting agenda and follow-up items ☐ Action Item: Approval of Minutes of February 26, 2020 Task Force Meeting	*Meeting Overview*
9:10 a.m.	**Subject Matter Expert Presentation –** Francoise Cleveland, AARP Idaho, Associate State Director of Advocacy	*5-minute presentation 5-minute Q & A*
9:20 a.m.	**Subject Matter Expert Presentation –** Paul Glassman, DDS, MA, MBA, Assistant Dean for Research, College of Dental Medicine at California Northstate University and Professor Emeritus at the University of the Pacific, Arthur A. Dugoni, School of Dentistry	*10-minute presentation 10-minute Q & A*
9:40 a.m.	**Subject Matter Expert Presentation, Medicare and Telehealth –** Trudy Bearden, PA-C, MPAS, NCQA PCMH CCE, Senior Consultant, Comagine Health	*10-minute presentation 10-minute Q & A*
10:00 a.m.	**Subject Matter Expert Presentation –** Rachelle Williams, RHD-EA, MS, Assistant Professor, Department of Dental Hygiene, Idaho State University	*10-minute presentation 10-minute Q & A*
10:20 a.m.	**Break**	*10-minutes*
10:30 a.m.	**Subject Matter Expert Presentation –** Waseem Ghannam, MD, MBA, MHSA, CEO and Co-Founder of Telehealth Solutions, telemedicine services for senior living	*10-minute presentation 10-minute Q & A*
10:50 a.m.	**Subject Matter Expert Presentation –** Neil Tantingco, Founder and CEO, Connected Home Living	*10-minute presentation 10-minute Q & A*

TIME	AGENDA ITEM	*OBJECTIVE*
11:10 a.m.	**Subject Matter Expert Presentation –** Madeline Russell, MBA, Lost Rivers Medical Center, Arco, Idaho	*10-minute presentation 10-minute Q & A*
11:30 a.m.	**Identify Action Items and Next Steps – Krista Stadler, Co-Chair** □ Key questions for next steps □ Identify research/information/data needs prior to next meeting □ Identify action items	
12:00 noon	**ADJOURN**	

TeleT

Telehealth Task Force

April 29, 2020 On Line Meeting
9:00 a.m. Mountain Time

Action Items:

Action Item 1 – February Telehealth Task Force (TTF) Meeting Minutes

TTF members will be asked to adopt the minutes from the February 26, 2020 TTF meeting.

Motion: I, _____move to accept the minutes of the February 26, 2020 meeting of the Telehealth Task Force as presented.

Second: _____

TeleT

Telehealth Task Force

February 26, 2020 at 9:00 am **Location: 700 W. State St., JRW Building East Conference Room**

Meeting Minutes:

Member Attendees: Craig Belcher, Paul Coleman, Aleasha Eberly, Eric Forsch, Eric Foster, Doug Fry, Jenni Gudapati, Chad Holt, Susie Pouliot, and Krista Stadler

Ex Officio Members: David Bell

Members Excused: Rick Naerebout
Members Absent: Patrick Nauman

Guests: Susan Ault, Matt Ayers, Kimberly Beauchesne, Sophia Brasil, Cindy Brock, Francoise Cleveland, Abhilash Desai MD, Lee Flinn, Julie Hart, Ann Lawler, Pat Martelle, Ron Oberleitner, Tim Olson, Neva Santos, Chad Smith, Linda Swanstrom and Prudence Vincent

Phone: Dr. Scott Dunn, Scott Ehert, Randall Hudspeth, and Linda Rowe

DHW Staff: Mary Sheridan, Ann Watkins, Marissa Guerrero, Stephanie Sayegh

Summary of Motions/Decisions:

Motion:	**Outcome:**
Susie Pouliot moved to accept minutes of the January 22, 2020 meeting of the Telehealth Task Force as presented. Eric Forsch seconded the motion.	**Passed**
Aleasha Eberly moved to accept the Charter of the Telehealth Task Force as presented. Susie Pouliot seconded the motion.	**Passed**
Susie Pouliot moved to accept the TTF Member Communication Protocols of the Telehealth Task Force as presented Eric Foster seconded the motion.	**Passed**

Aleasha Eberly moved to accept David Bell, Deputy Administrator for Policy, Division of Medicaid, Department of Health and Welfare as an ex officio member of the Telehealth Task Force. **Passed**
Doug Fry seconded the motion.

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; and Agenda Review- *Craig Belcher, Co-Chair*

- Roll call, introductions and review of the agenda took place.
- All members of the telehealth task force have accepted their appointments and all those who were not able to attend the January meeting have participated in briefings hosted by the Co-chairs.
- To align efforts the telehealth task force and the Medicaid Telehealth Workgroup, David Bell, Deputy Administrator for Policy has agreed to serve as an ex officio member on the Telehealth Task Force.
- Charter Review – 12 members comprise the telehealth task force (4 representing healthcare and 8 representing Idaho based employers); subject matter experts with telehealth expertise will present at the February – May meetings – there will be approximately 6 SMEs presenting at each meeting. The SMEs will present use cases and their solutions to expand the adoption and utilization of telehealth in Idaho. The SMEs will also participate in the review of the draft final report prior to the submission of the final document to the Healthcare Transformation Council of Idaho members as well as to the Health Quality Planning Commission.
    - All the pre-implementation planning which commenced in September and concluded in December has been finalized and completed.
    - The recruitment of SMEs is on track with a wide variety of telehealth subject matter experts participating.
    - The final report will incorporate recommendations for legislative, policy and systemic changes, interoperability and information technology issues, as well as, ways to promote and educate healthcare providers and consumers about telehealth.
- The need to develop talking points for telehealth taskforce members to ensure consistent messaging and ongoing communication about the work of the task force was discussed. It was decided that following the conclusion of each meeting, TTF members will receive brief talking points they can share with their stakeholder groups and employees.
- Jenni Gudapati discussed and shared aggregated results of the pre-survey conducted with members of the TTF. Following the conclusion of each meeting, a post survey will be distributed by Boise State to all TTF members for their feedback and remarks.

Presentation by Medicaid- *David Bell, Deputy Division Administrator and Cindy Brock, Medicaid Program Policy Analyst*

Key points of the presentation – The Idaho Telehealth Access Act and IDAPA guidelines provide the framework for Medicaid telehealth program. In 2016 and 2018, codes were added to support telehealth

payment and utilization by Medicaid providers. Currently there are a total of 35 codes for covered services. In 2018, technology requirements were also simplified. Medicaid is forming a workgroup comprised of Medicaid Subject Matter Experts to evaluate new codes, monitor program and regulatory changes and identify access issues. They will be tasked with reviewing Medicare and other carrier policies as well as evaluating best practices to make Idaho specific recommendations.

Questions or request for additional information: TTF members requested copies of the Medicaid Provider Handbook, clarification on HPSA (health professional shortage area) verses rural/urban point of service location requirements, and a copy of the patient handbook which informs them of telehealth Medicaid service options. There was a request for additional data on school-based telehealth utilization- e.g., has this program enhanced access or did it replace in person services?

Presentation by Saint Alphonsus Health System- *Kimberly M. Beauchesne, MHS; Manager, Strategy and Telehealth*

Saint Alphonsus supports a variety of telehealth services in different care settings across Idaho and Eastern Oregon providing services in rural and urban settings, internal and external to Saint Alphonsus. They offer outpatient, emergency and inpatient, education and direct to consumer services. Inconsistent policies across the payor landscape create access barriers to telehealth services. Administrative hurdles such as payor enrollment, executing delegated credentialing agreements, and delays in licensing slows the deployment of new services.

Ideally, clear and consistent telehealth reimbursement policies across all payors that does not require real-time validation of covered benefits for standard services would alleviate some telehealth system delivery issues.

Behavioral Health Panel- *Ron Oberleitner, MBA; Abhilash Desai, MD; and Pat Martelle, LCSW, MPH*

Ron Oberleitner presented an autism use case and highlighted the benefits of utilizing asynchronous telehealth and remote monitoring/patient-centric applications. Telehealth is particularly useful in autism treatment because 25% are non-verbal and can't communicate their behavioral health needs and frequently behaviors rarely appear during office visits. Minimizing distance and travel to providers is also helpful when treating autism. Telehealth also can help reduce diagnosis/response time, clinical time and lessens data collection errors as well as ways to measure progress.

Dr. Desai presented a use case on opioid and substance abuse treatment and focused on illustrating the benefits of a collaborative care team structure. He highlighted his telehealth work in long term care facilities and nursing homes and how the provision of this type of service is supported in a value-based environment. Dr. Desai emphasized the need for interoperability through the utilization of electronic health records and the use of HIPAA compliant audio-video platforms as well as the need for additional primary care provider education through programs such as Project ECHO. He talked about how telehealth is an effective mechanism for 1) treating patients more immediately; 2) keeping patients out of the ER and addressing alternative pain management options other than opioids.

Pat Martelle presented on Serious Emotional Disturbance (SED) with a use case focusing on treatment of teens. Telehealth solutions in the delivery of behavioral health services for children help promote

prevention services and early intervention. Accessibility of services via phone or computer add to the convenience factor. A care coordinator/navigator can stay in touch with family/youth regularly through texts, calls, emails for coaching, educating and navigating encourages participation. Assessments are scheduled at convenient times and can occur in the home of location of their choosing. Records are shared through a common platform with treatment team members and ensures HIPAA compliance. Treatment teams are developed and can communicate via test and email. Teams can convene via telehealth applications and collaborate to develop a treatment plan driven by the family and the child. The care coordinator ensures execution of the treatment plan, provides oversight and monitoring and ensures the treatment plan is updated regularly. Supportive communication can occur between the care coordinator and the family and child via texting, phone calls and emails.

Krista Sadler asked what actions are needed for this type of communication to be implemented? The panel recommended: leveraging real time telehealth services when possible, exploring telehealth parity, expanding School Based Telehealth services, and funding Project ECHO. One of the biggest priorities the panel advocated is to promote and utilize Collaborative Care team-based models and incorporate asynchronized telehealth as a treatment option. The panelists also reinforced the need to investigate more ways to communicate with behavioral health patients by using HIPPA compliant technology that still maintains the standard of care for patients.

Follow-up Items for Next Steps- *Krista Sadler, Co-Chair*

- IDAPA Medicaid rules and Medicaid Policy citations pertaining to Medicaid telehealth services
- Medicaid Provider Handbook
- Patient handbook which informs them of telehealth service options
- Clarification of School Data on Behavioral Health (e.g., was access increased or did telehealth replace in person visits?)
- Behavioral Health Panel SMEs are to bring back data on:
  - Further information on Atlanta evidence-based study
  - Any additional statistical information/articles on telehealth utilization and compliance in other areas
  - Percentage of time for no show patients
- Ann Watkins to provide more information on Inducement Law and OIG Stark consideration at the next meeting.

Ann Watkins introduced Chad Smith from Stonewall Analytics who has been hired by DHW to conduct a Telehealth Environmental Scan including a literature review, key informant interviews, survey design/deployment of survey to a broad base of telehealth utilizers in Idaho and production of a final report on results. By June, Stonewall Analytics will share high level results with members of the TTF to assist in alignment of efforts.

Meeting Adjourned: 11:55 a.m.

Next Meeting: March 18, 2020 from 9 a.m. – 12 noon MST

BIO

Françoise Cleveland joined the Idaho office of AARP in 2016 as the Associate State Director of Advocacy working within the organization's structure to provide state and federal government relations, grassroots organizing, and community outreach.

29 APR 2020

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Telehealth Task Force

THE PROMISE OF TELEHEALTH:

Helping consumers and family caregivers in Idaho

Françoise Cleveland
Associate State Director of Advocacy
AARP Idaho

AARP® Real Possibilities
Idaho

Why is AARP involved?

- Our members use technology to access information about their health.
- Telehealth has great potential for acute care, but also for helping people live in their homes and communities as independently as possible.
- Benefits to family caregivers are huge.

Impact of telehealth on Idahoans age 50+

- Reduced hospitalizations and readmissions
- Prolonged autonomy
- Improved quality of life
- Less waiting/faster response
- Less wear and tear
- Lower costs

Impact on Unpaid Family Caregivers

- 200,000 in Idaho
- Provide $2.3 billion in care annually
- Caregivers report:
  - High stress
  - Lost wages
  - Unprepared for medical tasks
  - Neglect of their own health

AARP® Real Possibilities
Idaho

Telehealth and Family Caregivers

- Brings health services to family caregivers at home.
- Bridges the gap for specialty care.
- Helps family caregivers take care of their own needs – physical, mental or emotional.
- Working and long-distance family caregivers can virtually join their loved ones' medical visits, so they can help manage their care.

Idaho telehealth landscape: today and tomorrow

- Idaho House Bill 342
- COVID-19 waivers & opportunities
- Continue to remove barriers that limit or prevent accessing care via telehealth
- Education
- Telehealth coverage parity
- Broadband

Questions?

Contact Information:
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Associate State Director of Advocacy
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(208) 855-4005

AARP® Real Possibilities
Idaho

BIO

Dr. Paul Glassman is the Assistant Dean for Research at the College of Dental Medicine at California Northstate University in Elk Grove, CA and Professor Emeritus at the University of the Pacific, Arthur A. Dugoni, School of Dentistry in San Francisco, CA.

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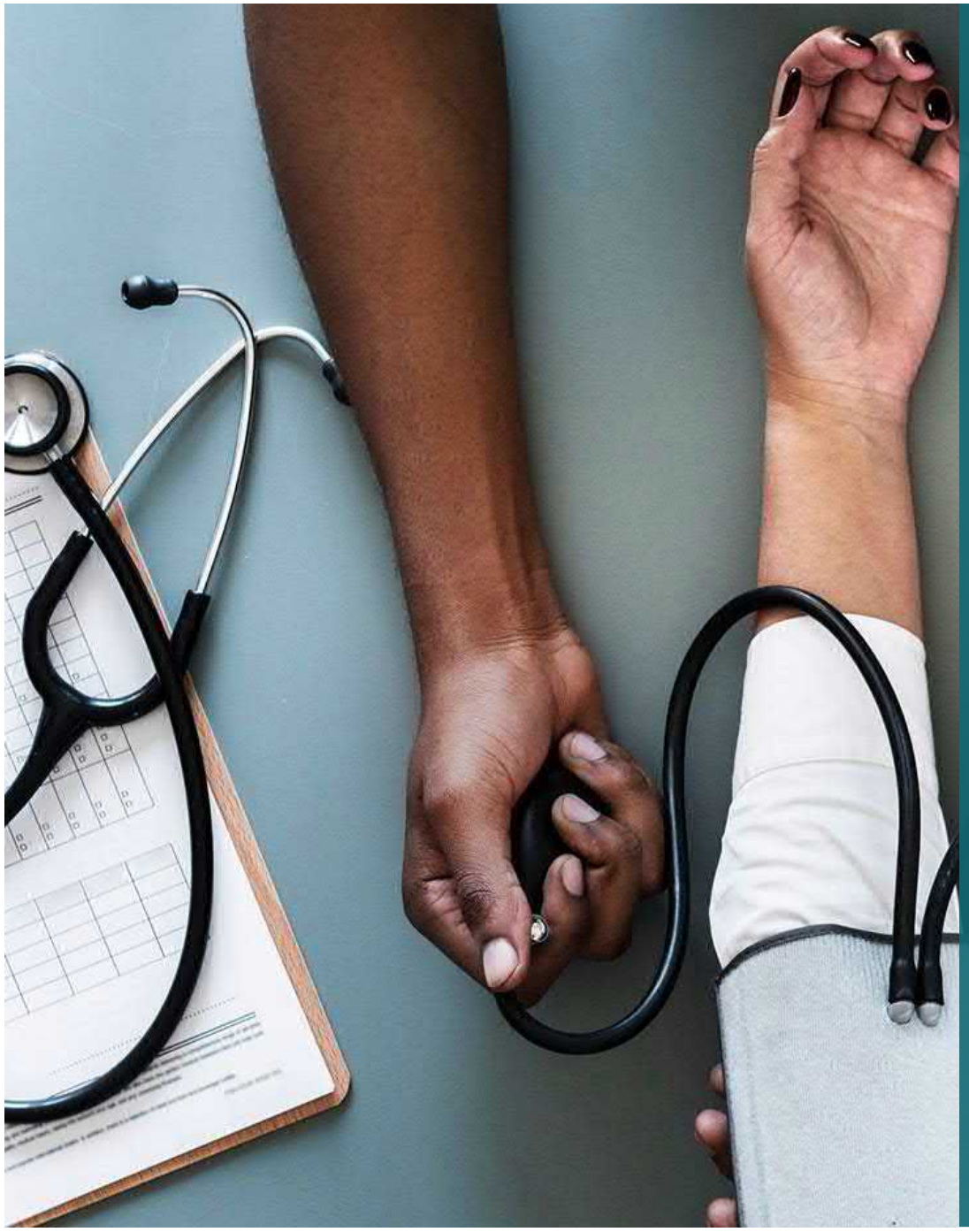


Paul Glassman DDS, MA, MBA
Professor and Associate Dean
California Northstate University
Elk Grove, CA
Paul.Glassman@cnsu.edu

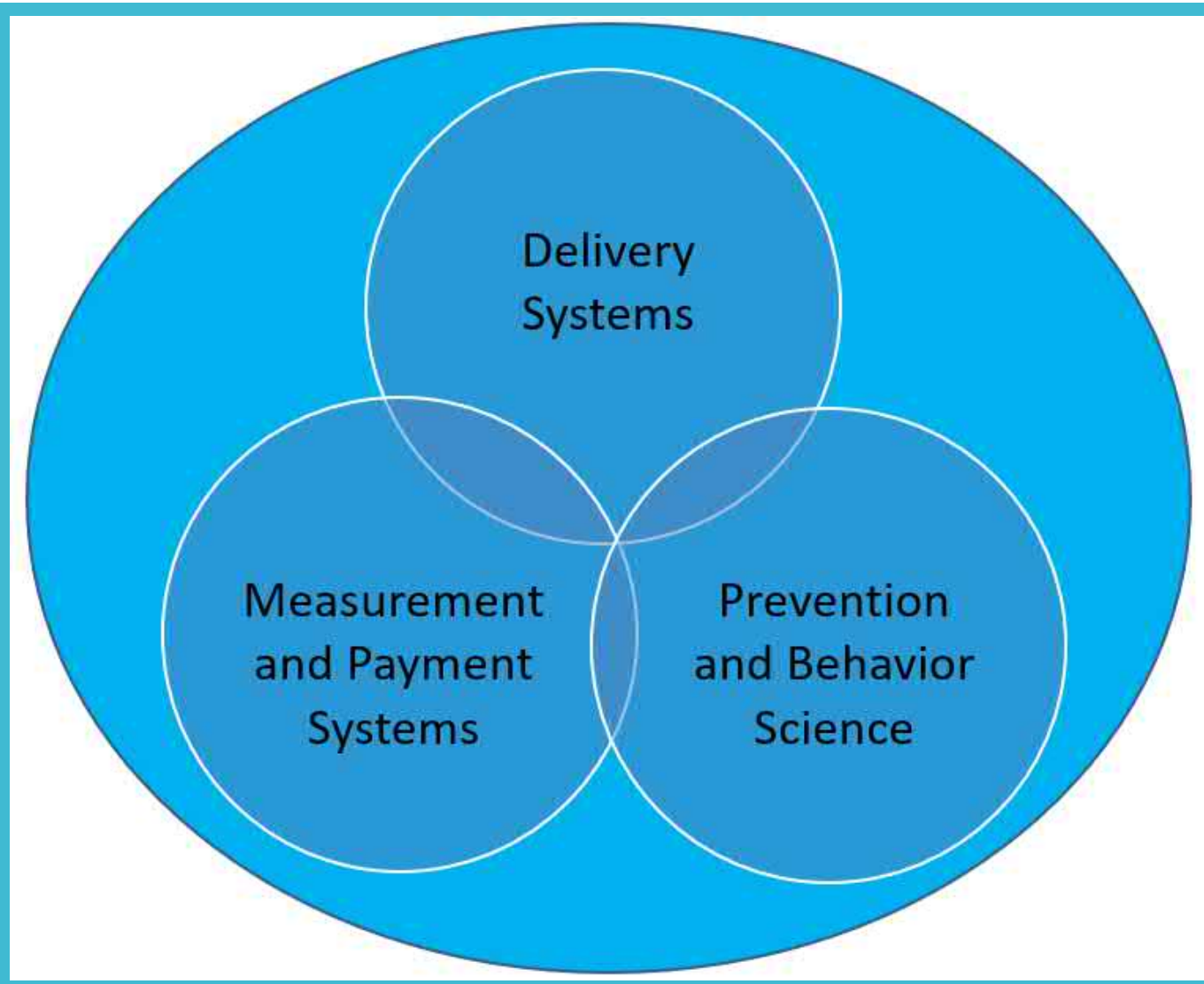
Telehealth Task Force Subject Matter Presentation

Presentation Date: April 29, 2020

About Us:

Dr. Paul Glassman is the Associate Dean for Research and Community Engagement at the College of Dental Medicine at California Northstate University in Elk Grove, CA and Professor Emeritus at the University of the Pacific, Arthur A. Dugoni, School of Dentistry in San Francisco, CA.

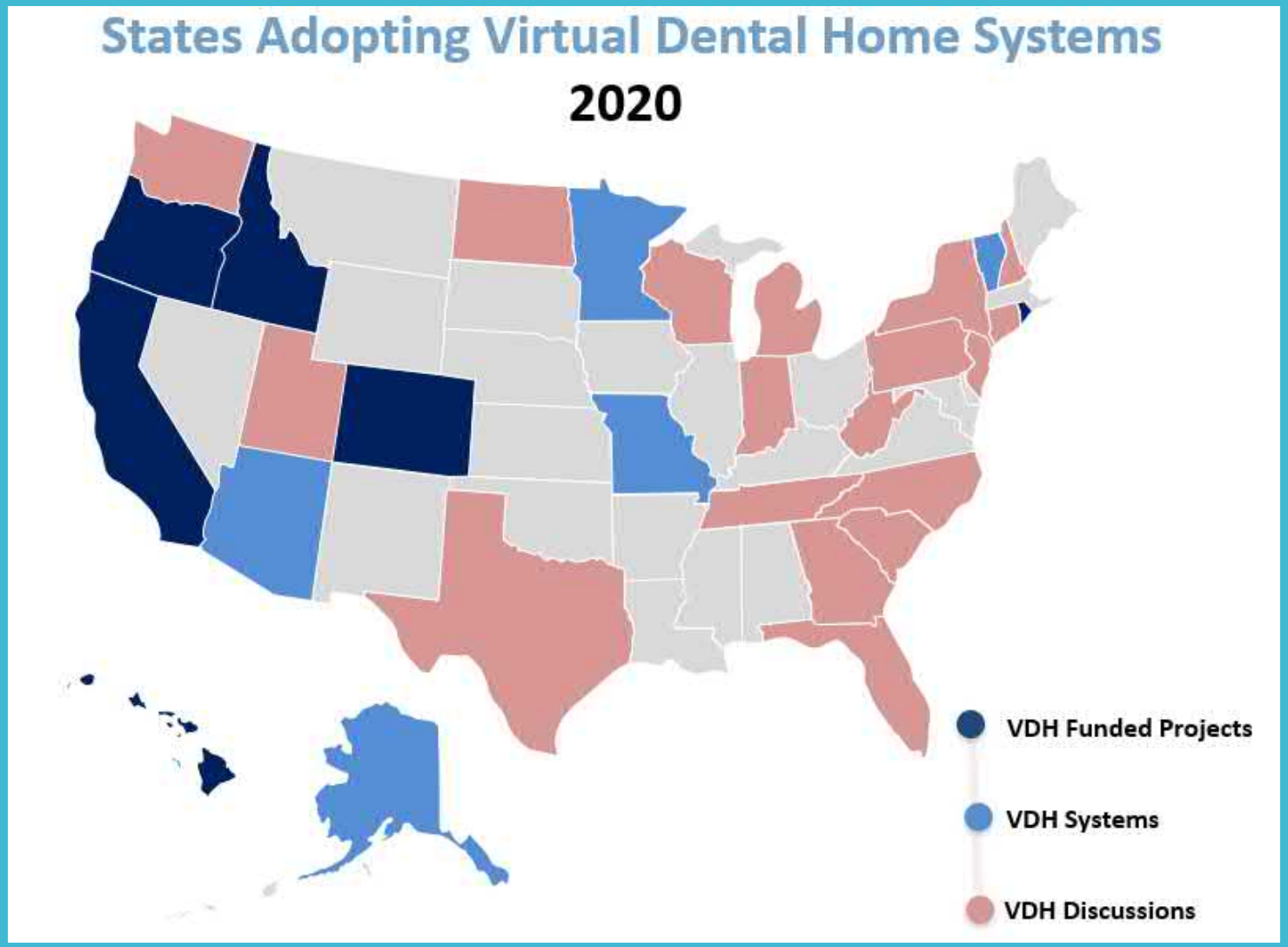
Dr. Glassman is a pioneer and has led the national movement to improve oral health using telehealth-connected teams and Virtual Dental Homes.


Delivery Systems
Measurement and Payment Systems
Prevention and Behavior Science

The Virtual Dental Home

Telehealth-Connected Teams and Virtual Dental Homes Key Outcomes

- Reach people, emphasize prevention, and lower costs
- Majority of people kept and verified healthy on-site
  - About 2/3 of children had all needed services completed by dental hygienist
- Continuous presence
- Community organization integration
- Dentist integration


States Adopting Virtual Dental Home Systems
2020
VDH Funded Projects
VDH Systems
VDH Discussions

OPEN Oral Health Progress and Equity Network

TELEDENTISTRY RESOURCES AND POLICY GUIDANCE

Before, during, and after COVID-19

BACKGROUND

The use of teledentistry as a means to expand access to oral health services has been gaining increased attention. There are a number of resources available to help individuals and policy makers understand the history, operational issues, and policy considerations in this area. The purpose of this document is to provide a listing of resources for background on these topics followed by some current policy proposals that could be pursued at the state level. That is followed by information about the role of the federal government and philanthropy.

PUBLICATIONS

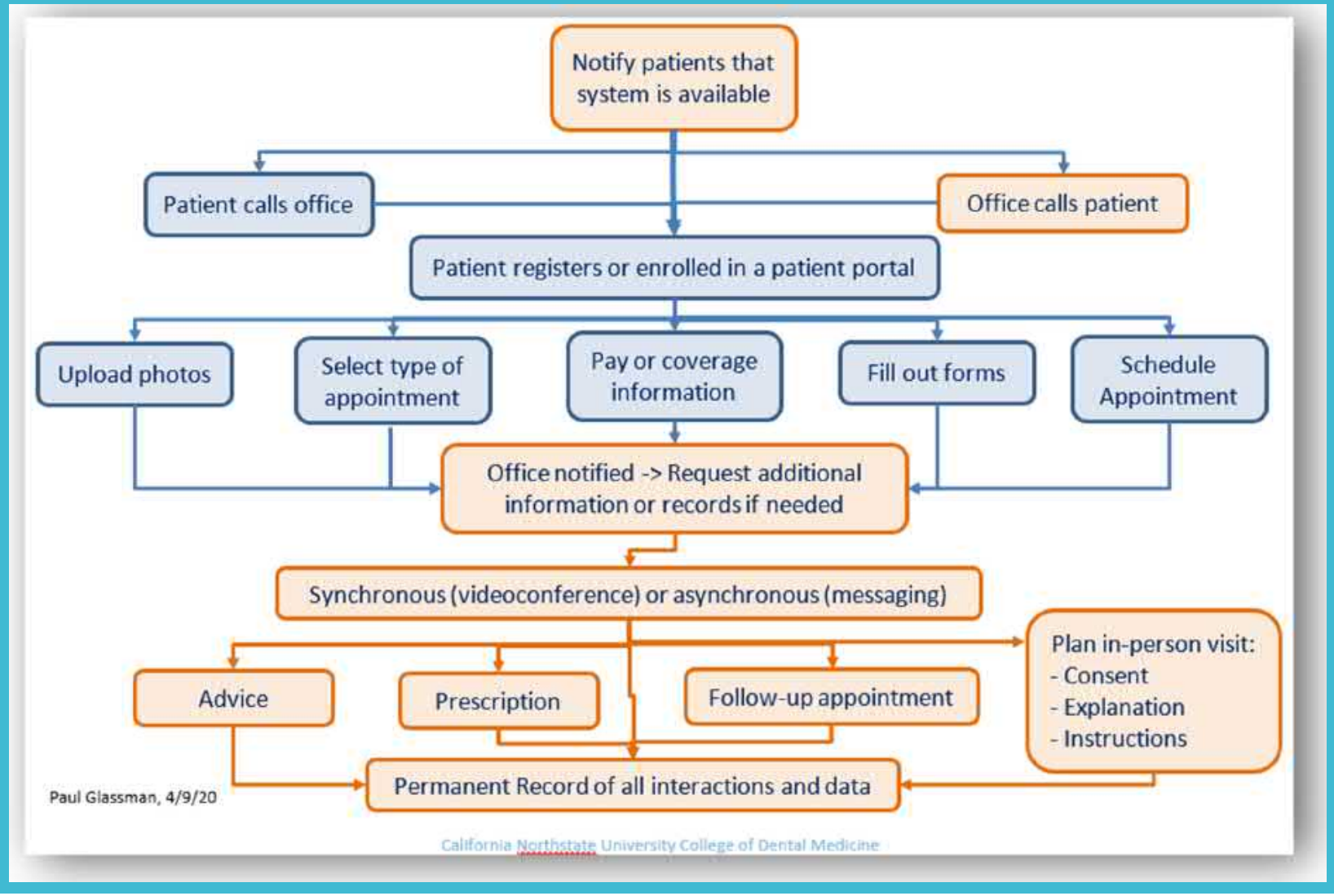
- The DentaQuest Partnership: Improving Oral Health Using Telehealth-Connected Teams and the Virtual Dental Home System of Care: Program and Policy Considerations. This is a general overview of the field of teledentistry, provides examples of programs in operation, and provides general policy recommendations.
- Paul Glassman DDS, MA, MBA: Using Teledentistry to Maintain Services and Contact with Patients During the time of COVID 19 Physical Distancing. This document provides principles for using teldentistry to reach patients and provide services in the current distancing environment. It describes components of an "optimized" system and information about ways providers can use some or all of those components.
- DentaQuest Partnership: Teledentistry Web Page. This page has links to a number of teledentistry resources including white papers and policy papers.
- Paul Glassman DDS, MA, MBA: Suggested Teledentistry Rules. This document contains policy recommendations that state legislators or regulatory agencies can adopt to support adoption and use of teledentistry and facilitate care systems.
- American Dental Association: ADA Coronavirus (COVID-19) Center for Dentists. This web site contains many documents related to infection control, operations, and billing for services that apply in the current physical distancing environment.

WEBINARS

There are a number of recorded webinars that provide useful information about responses in the COVID-19 physical distancing environment. Links to these recorded webinars are listed here:

- American Dental Association. March 31, 2020 webinar on Teledentistry & Virtual Evaluations During COVID-19.
- Elevate Oral Care. April 6, 2020 webinar on Teledentistry and Minimally Invasive Procedures in the Time of COVID-19.
- DentaQuest Partnership. April 6, 2020 webinar on Teledentistry: Providing Alternative Care During a Public Health Crisis.
- National Network for Oral Health Access (NNOHA). April 15, 2020 webinar on Engaging Dental Providers in COVID-19 Response Efforts. The link below is the NNOHA web page with links to webinar recordings and slides.
- NNOHA also has a web page with additional resources on teledentistry.
- Southern Arizona Oral Health Coalition, April 7, 2020 Practical aspects and examples of teledentistry.
- Arcora Foundation of Delta Dental of Washington. Teledentistry 101 & COVID-19 Limited Evaluations.
- Indian Country ECHO. Teledentistry: Providing Care During COVID-19 Crisis.
- Missouri Coalition for Oral Health. Teledentistry in Missouri During the COVID-19 Pandemic.

JOIN US! WWW.ORALHEALTH.NETWORK


Notify patients that system is available
Patient calls office
Office calls patient
Patient registers or enrolled in a patient portal
Upload photos
Select type of appointment
Pay or coverage information
Fill out forms
Schedule Appointment
Office notified -> Request additional information or records if needed
Synchronous (videoconference) or asynchronous (messaging)
Advice
Prescription
Follow-up appointment
Plan in-person visit:
- Consent
- Explanation
- Instructions
Permanent Record of all interactions and data
Paul Glassman, 4/9/20
California Northstate University College of Dental Medicine

Teledentistry Rules
February 10, 2020

Prepared by

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Introduction

This document contains a list of suggested rules based on rules that have been adopted in various states to define, regulate, or explain the use of telehealth technologies in the provision of dental care. It is intended as a general guide for states or regulatory agencies contemplating rulemaking about tele-dentistry.

OPEN Oral Health Progress and Equity Network

TELEDENTISTRY RESOURCES AND POLICY GUIDANCE

Before, during, and after COVID-19

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- Missouri Coalition for Oral Health. **Teledentistry in Missouri During the COVID-19 Pandemic**.

ADDITIONAL STATE POLICY RECOMMENDATIONS

In addition to the general policy recommendations described in the Suggested Teledentistry Rules and other documents listed above, there are several other policy actions that states and regulatory agencies could take to facilitate the use of teledentistry in the current environment. These include communicating through regulations or guidance on the following:

- The state dental Medicaid program will pay oral health providers for currently covered procedures whether they are performed in-person or performed using synchronous or asynchronous telehealth technologies. State Medicaid programs can cover teledentistry-related codes without submitting a state plan amendment (SPA), so long as the payment methodology does not differ from that of in-person services. If the state wishes to implement a different reimbursement structure for teledentistry services than is currently in place for the same in-person services, the state would need to submit a SPA, but may be able to have the process expedited through the emergency SPA process.
- Specifically, the state dental Medicaid program can cover procedure code D0140 (problem focused evaluation) whether performed in-person or performed using synchronous or asynchronous telehealth technologies.
- The state dental Medicaid program can specify that they allow providers to establish patients as their patients using synchronous or asynchronous visits as well as in-person visits.
- State regulatory agencies can alter scope of practice policies to enable the delivery of oral health care via teledentistry. In some cases, state licensing bodies such as the board of dentistry, may need to suspend enforcement of prohibitions on teledentistry or simply eliminate those restrictions altogether. In order to ensure equitable access to care, additional restrictions on which provider types may perform certain teledentistry services and whether such services require direct supervision may also need to be adjusted. For example, if advanced practice dental hygienists or dental therapists are authorized to practice in a state, policies governing teledentistry could enable them to utilize telehealth technology to operate under remote supervision where appropriate.

STATE EXAMPLES

- The South Carolina Board of Dentistry temporarily lifted the prohibition against the practice of dentistry via telehealth and issued **emergency guidelines** for dental providers.
- North Carolina's Medicaid agency has modified its **policies related to teledentistry**, specifying that teledentistry services may be provided "to triage or evaluate beneficiaries with urgent or emergent oral health problems." However, North Carolina does not allow dentists to delegate provision of such services to dental hygienists or other oral health professionals.
- Virginia Health Catalyst created a **crisis teledentistry implementation guide** that may serve as a model for other states.
- According to the **National Conference of State Legislatures (NCSL) web site** on Oral Health Providers, at least 20 states have enacted policies related to reimbursement for teledentistry services in Medicaid or private insurance. However, many states have no specific policies or regulations in place, further underscoring the need for advocates to contact their state Medicaid agencies and boards of dentistry to ensure that remote care can be provided to patients in need.

States Medicaid and other health agencies should also work closely with state dental associations, Medicaid managed care plans, and dental benefit administrators, to identify any informational or training resources necessary to ensure that providers are confident in delivering services like evaluations and consultations with patients via telehealth technology.

FEDERAL RESOURCES

The CARES Act included $180 million for existing grant programs through the Health Resources and Services Administration (HRSA) to support rural hospitals, rural tribal health and telehealth programs. In addition, the bill provides over $1 trillion in funding to the Indian Health Service for COVID-19 response, including supporting telehealth.

Proposals released by House Democrats would further support the delivery of telehealth in Medicaid by increasing federal matching dollars for certain services. However, at this point, the proposal does not include dental services. Advocates should encourage their members of Congress to provide enhanced matching funds for services beyond what is currently available in Medicare, including teledentistry services.

ROLE OF PHILANTHROPY

Philanthropic organizations can bolster the capacity of the system by funding telehealth technology, training, and other resources necessary for providers to deliver care via teledentistry.

BIO

Trudy Bearden is a Senior Consultant at CoMagine, providing comprehensive technical assistance to sites pursuing practice transformation. Her consulting expertise extends to health information technology, HIPAA, and the EHR Incentive Programs.

29 APR 2020

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Telehealth Task Force

Comagine Health

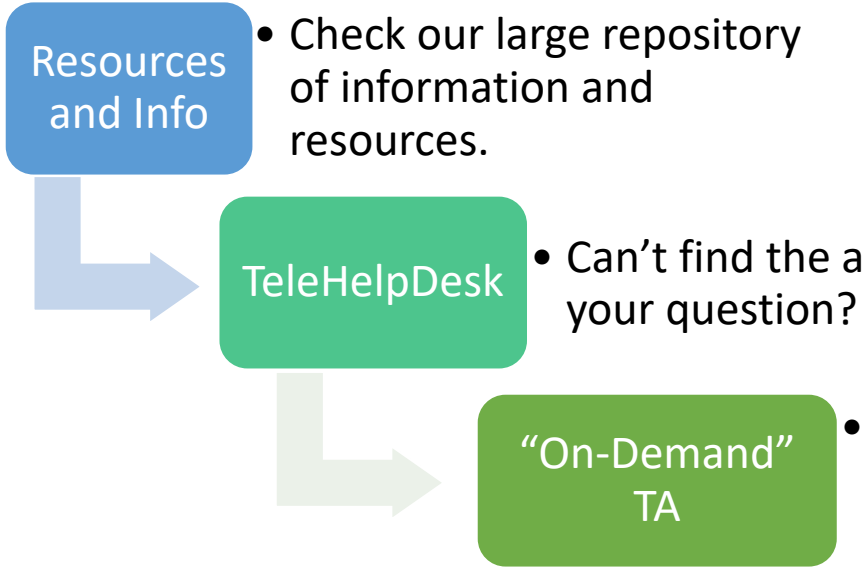
Idaho Telehealth Task Force Meeting

Date: April 29, 2020

Time: 9:40 am – 10-min presentation with 10-min Q&A

Rapid Response Telemedicine Team
Six-Member+ Team

- GUIDING PRINCIPLE: **We do not want to add to the "noise."**
- Telemedicine and Virtual Services Resources website identified as top priority with tiered approach



Opportunity to coordinate efforts?

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Comagine Health

Medicare Virtual Care Services

- Medicare Telehealth Services: interactive two-way audio and video
- Virtual Check-Ins and Remote Evaluation of Pre-Recorded Patient Information
- E-Visits
- Telephone Evaluation and Management (E/M) Services (only for the duration of the public health emergency)
- Remote Physiologic Monitoring
- Chronic Care Management
- Transitional Care Management
- Interprofessional Consultation Services
- Behavioral Health Integration

Telemedicine Strategies

Now until end of the public health emergency

- Assist in prioritizing how interrupted care will be restored
- Protect jobs - capture and enhance revenue
- Focus on safety and infection control
- Enhance access
- Plan to address chronic and preventive gaps in care (concerns with CQMs/UDS)
- Identify and address barriers (e.g., bandwidth, connectivity)
- Advocate for telemedicine promotion and expansion so we don't lose the gains
- Stay current on regulatory changes as public health emergency draws to a close

Telemedicine Strategies
Post public health emergency (PHE)

- Hold the gains and advocacy
- Provide curated, high-quality resources/technical assistance
- Make the business case and patient/staff experience case
- Identify and address barriers to sustainability
- Stay current on regulatory changes post PHE
- Align insurance carriers
- Measure (Comagine Health Analytics Team) and build telemedicine use into CQMs
- OTHER???

Telemedicine – Additional Considerations

- Health equity – who are our marginalized populations and how do we “lift all boats”? (e.g., insurance coverage, under-insured, homelessness, connectivity, etc.)
- Privacy and security – a new consideration especially for completing HIPAA-required security risk analyses – guidance for orgs?
- Fraud and abuse – CMS’ ongoing concern with telemedicine
- Person-directed health care service delivery – how do we preserve, promote and support the option of teleservices?
- Retention of certain PHE-specific provisions for RHCs, FQHCs, CAHs and LTPACs – DISTANT SITE especially
- Parity in reimbursement for telemedicine
- OTHER???

CAH-critical access hospital; FQHC-federally qualified health center; LTPAC-long-term and post acute care; RHC-rural health clinic

Questions & Discussion

Trudy Bearden, PA-C, MPAS
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Comagine Health

BIO

Rachelle Williams, RDH, MS has over 18 years of clinical experience and has been an educator for 6 years in the Department of Dental Hygiene at Idaho State University. Her research has focused on community oral health care, which included the development, implementation, and evaluation of a school-based sealant program.

29 APR 2020

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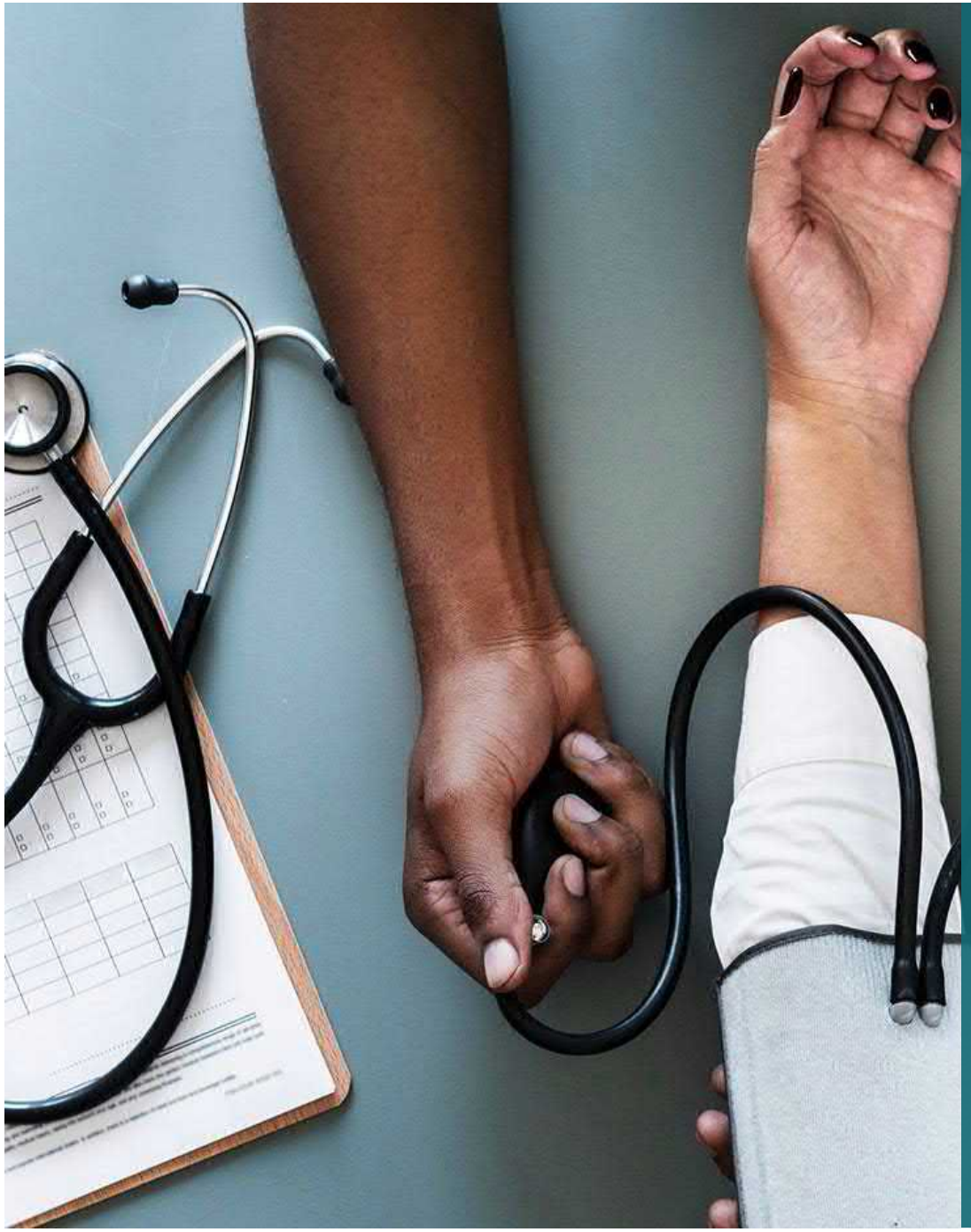
Telehealth Task Force



Rachelle Williams
RDH-EA MS

Telehealth Task Force Subject Matter Presentation

August 29, 2020

ISU Department of Dental Hygiene.

Bengal Smiles for Life

Program Implemented January 2020

Idaho State University Department of Dental Hygiene Teledentistry Program

Idaho State University

Case Study

Population:

50 Residents at Caring Hearts Assisted Living Center

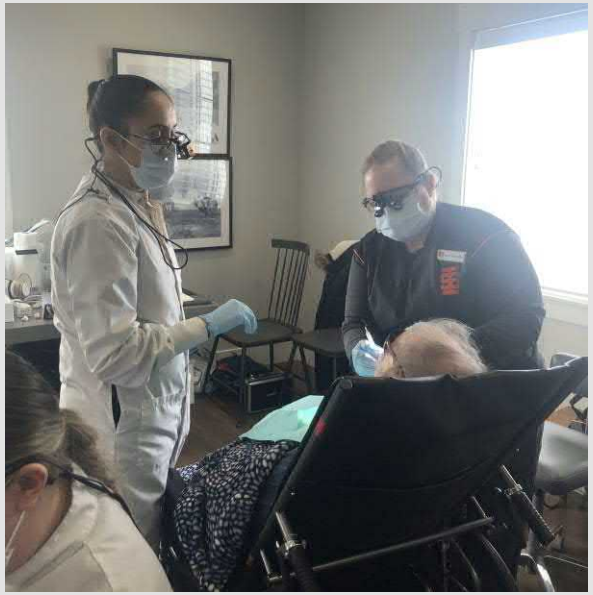
Medical/physical Challenges:

Various levels of dementia (cognitive limitations, decreased motor skills, limited mobility) common medical conditions include high blood pressure & type 2 diabetes

Common Oral Conditions:

High Caries Risk, Dry Mouth, Heavy Biofilm

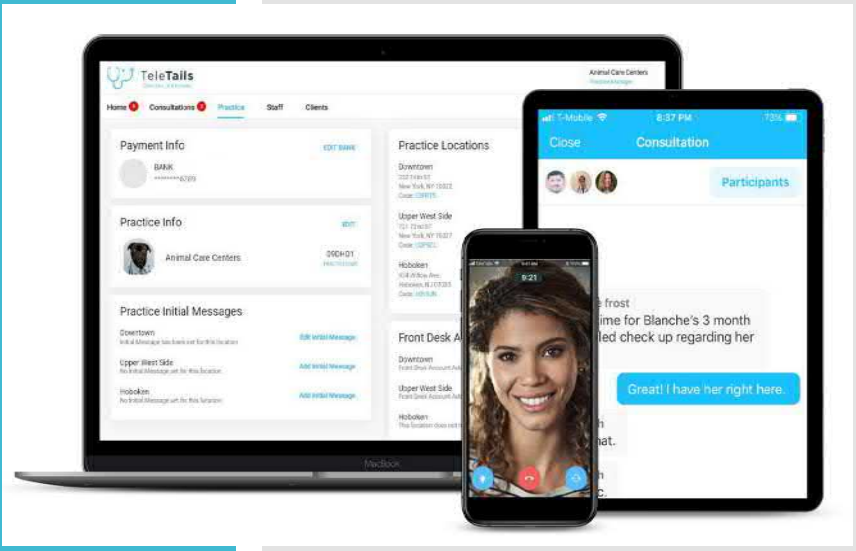
10% full dentures – 30% partial dentures – 60% full/partial dentition



Magic Wand For Telehealth:

Universal telehealth software capable of communication between all health professionals (dental and medical).

- Oral health care providers see patients every 3-6 months
- Direct communication with medical providers would allow discussions related to patients vital signs and medical conditions
- Universal software would allow communication between providers on a regular basis



Ideal Situation

Insurance reimbursement is an issue in Idaho for teledentistry.
Solution: telehealth exams covered for both dental or medical

Interprofessional interactions between health professions to provide overall health care
Solution: Universal software or integration of current software

Summary Conclusion:

Overall health requires teamwork between oral health specialists and medical specialists

Success of telehealth depends on medical and dental professionals working collaboratively

Contact Information:

Rachelle Williams
willrac5@isu.edu

Telehealth Task Force
Use Case Name: Caring Hearts Assisted Living Center
Presentation Date: April 29, 2020

Presenter: Rachelle Williams RDH-EA, MS
Presenter Email: willrac5@isu.edu

Use Case Description:

Population: 50 residents at an assisted living center (55+ years of age). All patients have dementia (varying stages). Limited mobility/motor skills, cognitive limitations. Minimal additional health conditions. High blood pressure and type 2 diabetes are common with most residents.

50 residents received oral health screenings in the fall of 2019. Full oral health care (exams via teledentistry, nonsurgical periodontal therapy, denture cleanings, fluoride varnish and silver diamine fluoride) began in January 2020. 12 residents received full oral health care services prior to COVID-19 restrictions.

Oral Conditions:
75% of these patients have not received professional oral health care in 1+ years. 10% have full dentures, 30% have partial dentures, and 60% have a partial or full dentition. Patients with partial or full dentition presented with moderate to heavy biofilm, gingival inflammation identified with oral screenings and 11 were later identified as periodontitis, dry mouth, and caries.

Treatment:
12 residents received oral health care prior to COVID-19
12 examinations
11 full mouth radiographs/intraoral photos
21 quadrants of RP/SC
13 teeth treated with SDF
5 partial denture cleanings
1 full denture (maxillary/mandibular) cleaning

Accomplishments and Quick Wins:

Interactions with the staff and residents began in September 2019 when oral health screenings were completed on 40/50 residents at Caring Hearts Assisted Living Center. During this time, we completed screenings and interacted with the staff and residents during activities, meal time, and visited residents who were unable to leave their room.

These types of interactions developed a team work attitude between the dental team and the Caring Hearts staff. In addition, residents were not as fearful of dental treatment because they were comfortable with the dental team. I highly recommend this type of approach.
We started this same type of approach at a second site prior to COVID-19 restrictions.

Quick win: Patients/residents who have been very fearful of oral health care (cried in the fall with oral health screenings) tolerated the spring appointment, which included radiographs, non-surgical periodontal therapy, and silver diamine fluoride.

Best Practices, Lessons Learned and A-Ha Moments (lessons learned):

Short appointments. In general, we found patients tolerate about 1 hour of care due to discomfort- hips, neck, jaw etc…

Listen to the staff when scheduling, they know which patients tolerate morning or afternoon appointments.

No appointments after 4:00PM due to sundowning symptoms in patient with dementia

Don't ask if patients with dementia want to do anything related to dental treatments – they will always say no! Best to say we are now going to do…..

Barriers and Challenges:

Physical limitations:
Caring Hearts has three buildings, the portable dental equipment is set up in a spare room in building #3. It is great to have a location to leave the equipment set up, however it requires busy CNA's to transport patients from buildings #1 and #2 to their appointments in building #3. Often patients are 30-40 minutes late for their scheduled appointment time.

Communication between healthcare providers:
Teledentistry software allows easy communication between the dental team onsite and the dentist offsite. However, it does not allow communication between the dental team and physicians. Overall patient health depends on this type of interaction

Reimbursement: Dental hygienists are not able to bill directly for services provided within scope of practice. Teledentistry and Silver Diamine Fluoride are not covered by dental insurance. It is

an additional barrier to find dentists to participate in teledentistry if they are not reimbursed. In addition, sustainability of teledentistry programs depend on reimbursement for dental procedures.

What is your magic wand scenario?

Universal telehealth software capable of communication between all health professionals (dental and medical).

- Oral health care providers see patients every 3-6 months
- Direct communication with medical providers would allow real time discussions
- Universal software would allow communication between providers on a regular basis

Reimbursement for all telehealth examinations (dental exams or physician consult)

Recommendations:

Increase interprofessional health care with the utilization of telehealth

BIO

Dr. Waseem Ghannam obtained his Medical Degree from St. Matthew's University and completed his training at Cabarrus Family Medicine in Concord, NC. He is the CEO and Co-founder of Telehealth Solution. They strive to provide telehealth technologies that bring care to patients at skilled nursing facilities and critical access hospitals. Their services focus on preserving a patient's integrity and dignity while reducing costs for the facilities.

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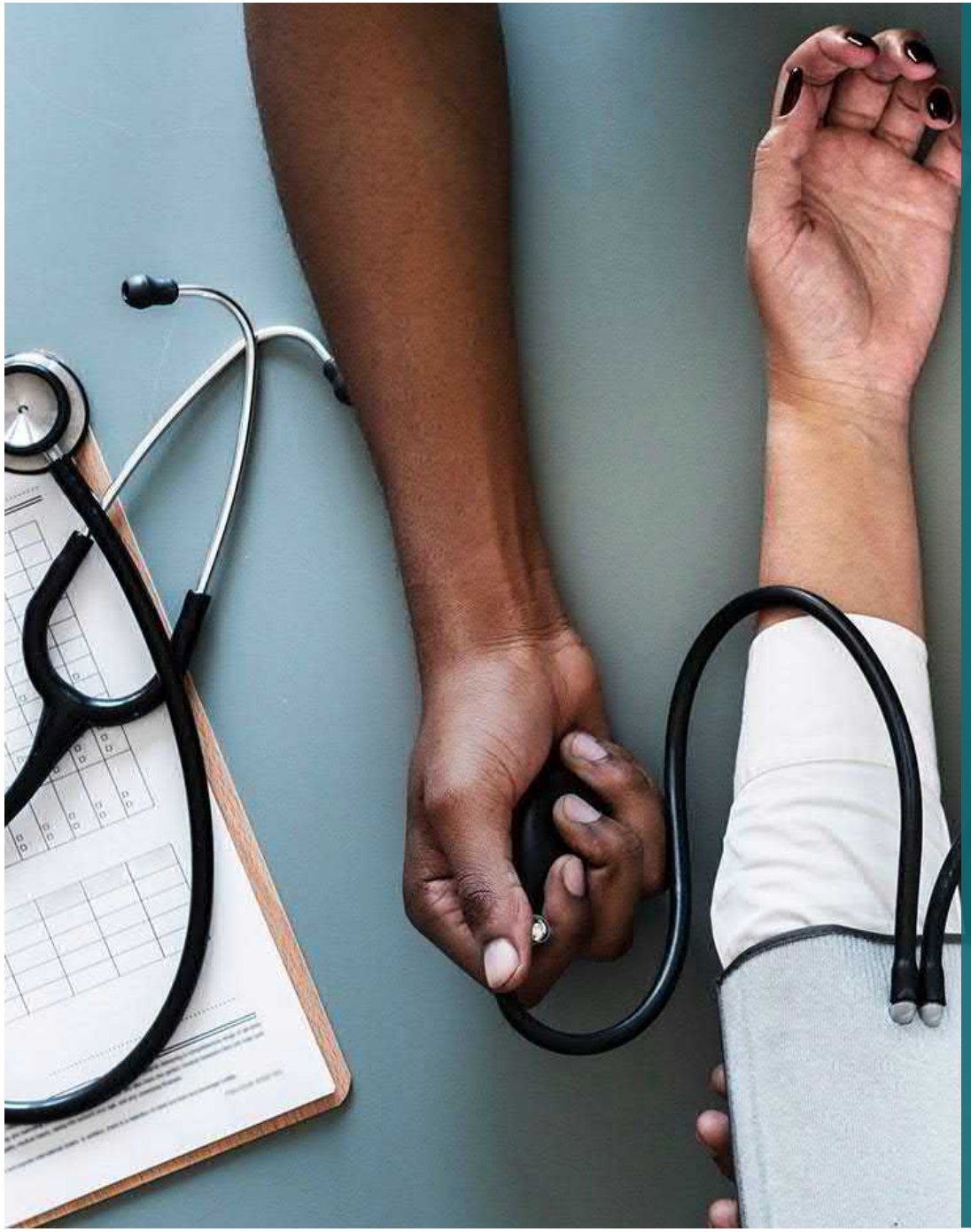


Dr. Waseem Ghannam, MBA MHSA

Telehealth Task Force Subject Matter Presentation

Telehealth Coverage in Skilled Nursing Facilities and Critical Access Hospitals

About Us:

Dr. Waseem Ghannam, MBA MHSA

- Graduated from Cabarrus Family Medicine Residency
- Co-Founded a private hospitalist group (LOCUM SERVICE)
- Co-Founded TeleHealth Solution, a private TeleMedicine company providing TeleHospitalist coverage in SNFs, AL, IL, LTACHs and CAHs

Executive Summary of our Case Study

Todays Specific Example of Care Will Focus On Skilled Nursing Facilities & Critical Access Hospitals.

1. What is the situation currently effecting Elderly Patients in SNF's across Idaho which results in High Readmission rates and bad care outcomes for the patient.

2. How telemedicine can upend those situations and create a "Treat In Place" approach with patients with outcomes where without telemedicine clinicians would result in a visit to the ED.

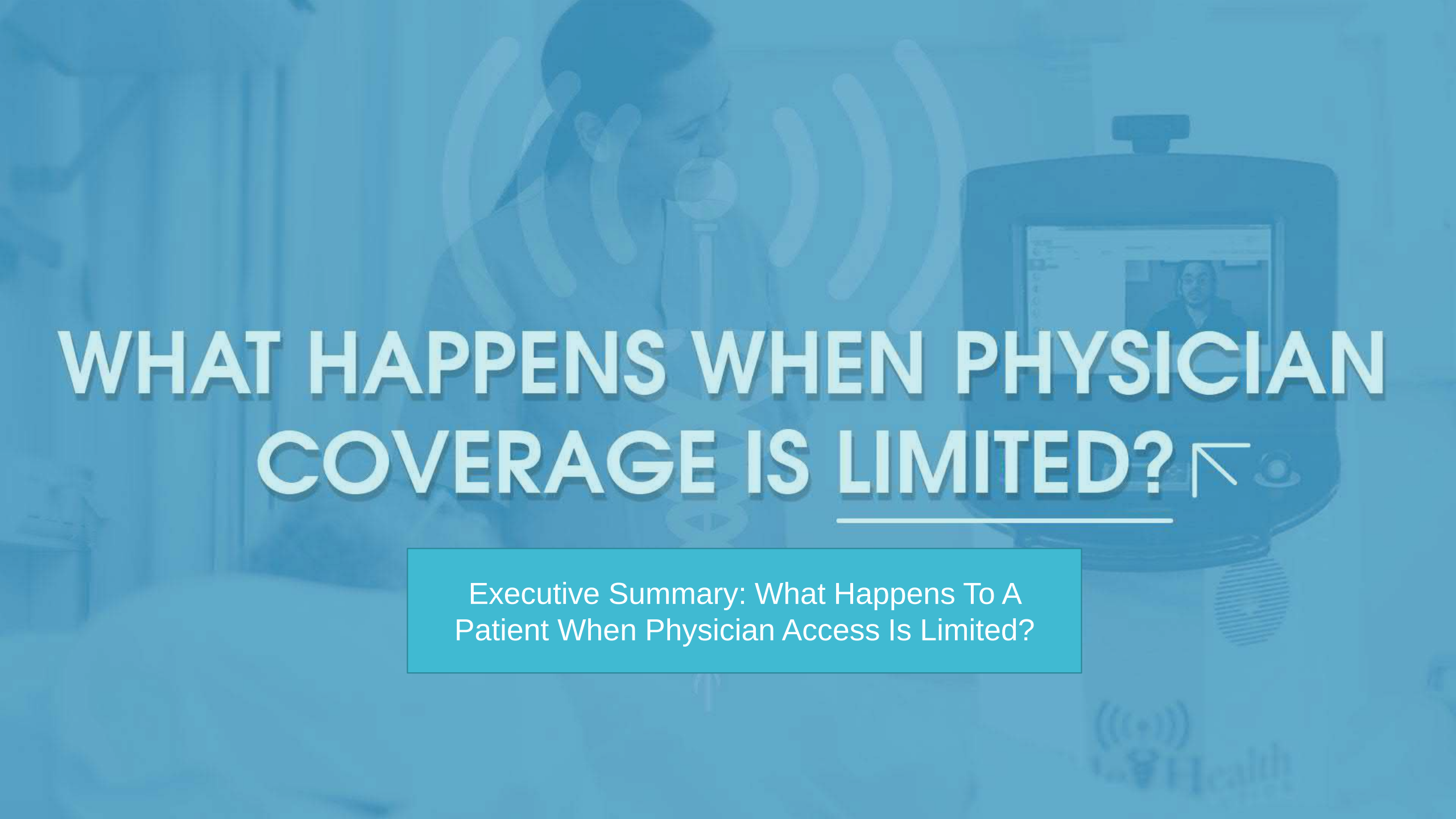
3. Explain the benefits of TeleMedicine In Critical Access Hospitals in a similar setting

TeleHealth in Idaho:

4. The Spectrum of TeleMedicine use State-wide

5. TeleMedicine in Idaho and how to implement the tools State-wide.

6. Closing Summary.



Executive Summary: What Happens To A Patient When Physician Access Is Limited?

Executive Summary: What Happens To A Patient When Physician Access Is Limited?

Patient Case Scenario

SKILLED NURSING FACILITY

Mrs. Smith is an 86 year old woman, in short term rehab as she had a recent stroke and comes to the facility with a PEG tube.

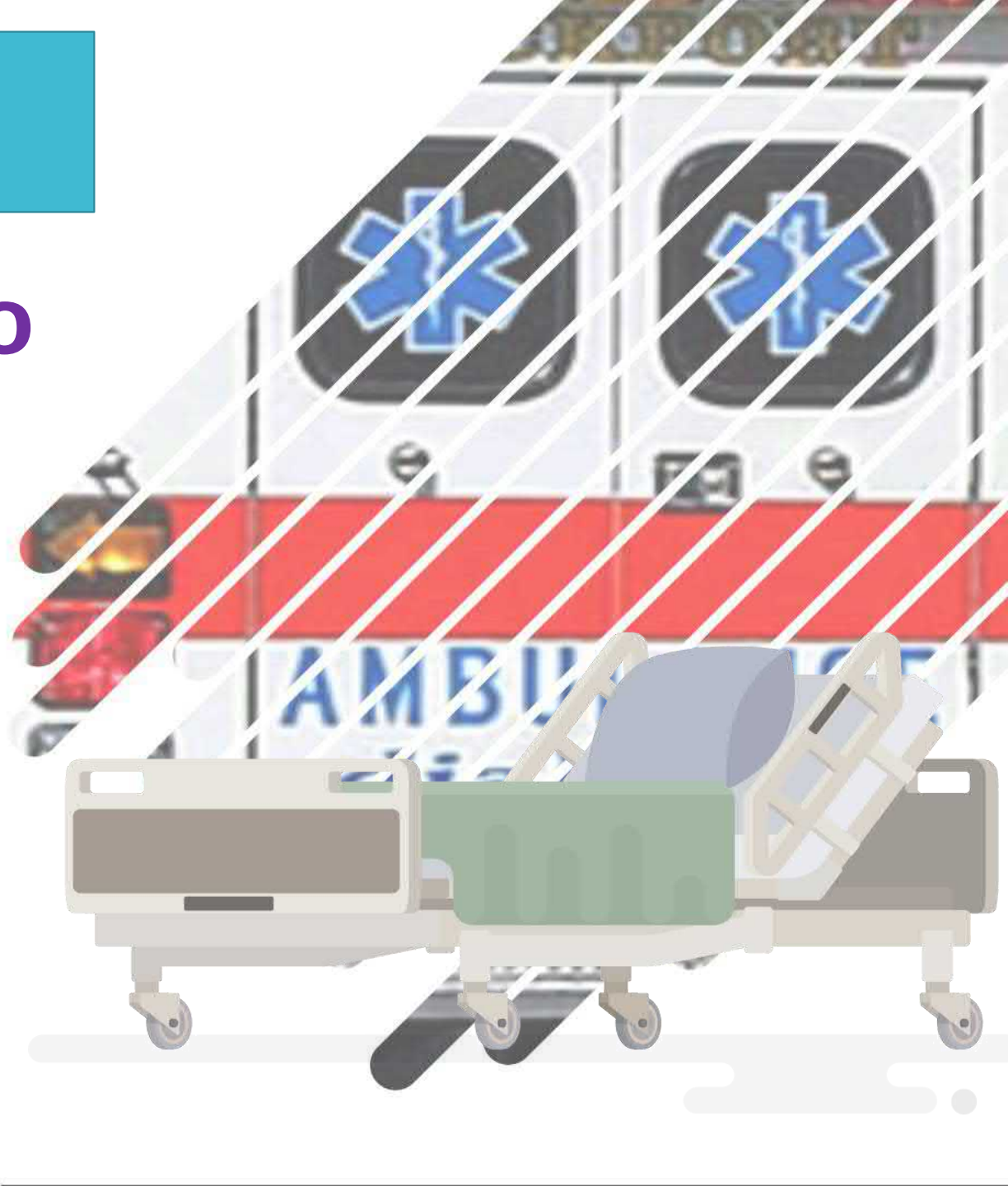
Saturday 3am, she is coughing, has a temp of 103.7, respiratory rate is 26, BP 110/62 Pulse ox 80% on room air Nurse calls the on call provider, and nurse ordered to send patient to the ER

Executive Summary: What Happens To A Patient When Physician Access Is Limited?

Patient Case Scenario

SNF - OUTCOME

- Patient transported via ambulance to the ER for evaluation then admitted for sepsis/PNA
- Patient suffered from hospital based delirium, is combative and doctor orders restraints
- The patient is admitted for 4 days in the hospital, the SNF gets penalized for 30-day readmission and looses reimbursement while she is in the hospital
- Mrs. Smith is further weakened by being moved multiple times from hospital to facility to hospital, recovery is delayed due to delirium, the experience is very stressful on the patient and family
- Patient incurs ambulance ride, ER, physician, and hospital costs



HOW TELEMEDICINE HELPS PREVENT READMISSIONS

Early Intervention & Management
(prevents conditions from worsening)

Cutting Edge Diagnostic Tools

Realtime Diagnosis & Treatment

Ability To Order Additional Labs/Tests Remotely

Tele-Hospitalist Work Closely With ER Physicians.

(With A Goal To Transition Back To Facility Avoiding A Readmission)

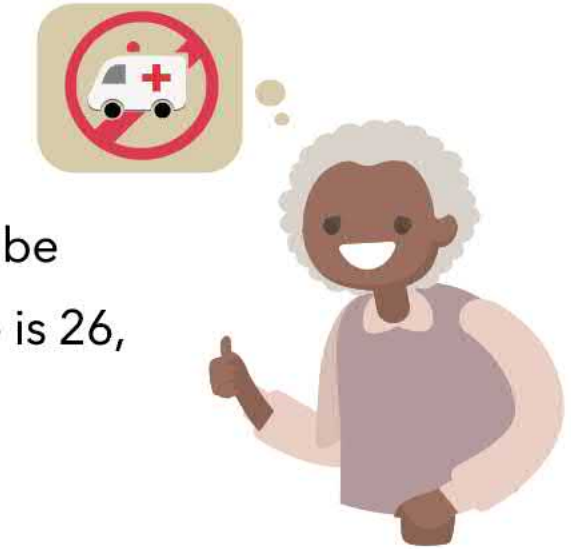
TELEHEALTH: True Care Scenario

THE ADVANTAGES OF TELEHEALTH IN SKILLED NURSING

Skilled nursing facilities (SNFs) can benefit tremendously from telehealth. According to research conducted by the Kaiser Family Foundation, 30 to 67% of hospitalizations among SNF residents could be avoided with interventions such as telehealth technologies. Readmission rates, increased access to specialized care, and cost savings are just some of the many benefits to post-acute care, when telemedicine becomes an integral part of their everyday care.

PATIENT SCENARIO OF CARE:

- Mrs. Smith - 86 year old woman
- Suffered from a recent stroke and comes to the facility with a PEG tube
- Saturday 3am, she is coughing, has a temp of 103.7, respiratory rate is 26, BP 110/62, Pulse ox 80%



TELEHEALTH: True Care Scenario (cont. p2)

HOW WE TREAT IN PLACE: MRS SMITH WORK FLOW

Mrs. Smith request nurse aid or has had an emergency

Nursing staff triages and evaluates the patient.

Nurse sends page request through app: TeleMedicine Physician begins encounter

High Priority Cases Upgrade Directly to Video Encounter

VIRTUAL CONSULT IS NEEDED

The cart is moved to the room, records reviewed, and patient is examined by our remote physician, leveraging telemedicine technology.

MOST CASES START WITH A CALL
Orders May Be Given Or The Consult Is Upgraded To A VIDEO ENCOUNTER

MD MAKES ORDER

Continued On Next Slide

TELEHEALTH: True Care Scenario (cont. p3)

MD MAKES ORDER

IMPROVED CLINICAL OUTCOMES:

The TeleHospitalist suspects aspiration pneumonia and creates treatment plan while patient remains in-house.

- NPO x 24 hrs
- Nutrition eval for tube feed rates adjustment
- CBC, BMP, CXR/KUB
- Appropriate Antibiotic PEG BID x 10 days
- Supplemental oxygen
- Albuterol nebs q4hrs x 24 hrs with q2hrs prn shortness of breath
- Resident monitored throughout
- D5NS 100cc/hr while off tube feeds

Note is generated in the patients EHR and admin is notified in AM

Continued resident follow up

PCP/Family coordination

WHAT IF THE PATIENT WENT TO THE ER?

ER FOLLOW UP = This system tracks and notifies our clinician team to seek return throughout a 24 hour period. Avoiding a 30 day readmission to the hospital when a patient is sent for non critical hospitalization

HOW WILL OUR DON / PCP / TEAMS BE NOTIFIED?

(Clinical Care Nurse Coordinator) CCNC FOLLOW UP = Reports high level follow-ups directly with DON's and PCP's immediately on shift start We also give manual tools to the PCPs and DON to access instant reporting on all encounters by THS clinicians.

TELEHEALTH: Critical Access Hospital Benefits

7 Areas Where TeleMedicine Benefit Critical Access Hospitals

Physician staffing costs

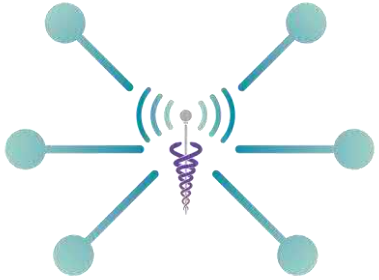
Quality physicians

Consistent, evidenced based medical care

Patient retention / transfers to tertiary care centers

Throughput/LOS metrics

Recruitment challenges



Ancillary Services

TELEHEALTH: Critical Access Hospital Benefits

Hospitalist

- Supervision on daily rounds and admissions
- Solo nighttime coverage or collaboration

Emergency Room

- ED Zones staffed by Residents and advanced trained APCs
- Board Certified ED physician available 24/7 to video assist if necessary

Cross Coverage:

- Phone consultation to review, triage and provide management decisions
- Telemedicine Video Encounter

Academics & Didactics:

- Ability to touch the community and treat patients in rural settings.
- Development of both clinical and nonclinical skills essential to Telehealth Delivery
  - *The Telehealth physical exam*
  - *Virtual doctor patient communication*

The Need for TeleMedicine in Idaho:

SKILLED NURSING FACILITIES (SNF)

ASSISTED AND INDEPENDENT LIVING COMMUNITIES

ACUTE INPATIENT REHABILITATION

OUTPATIENT CLINICS

EMERGENCY MEDICINE

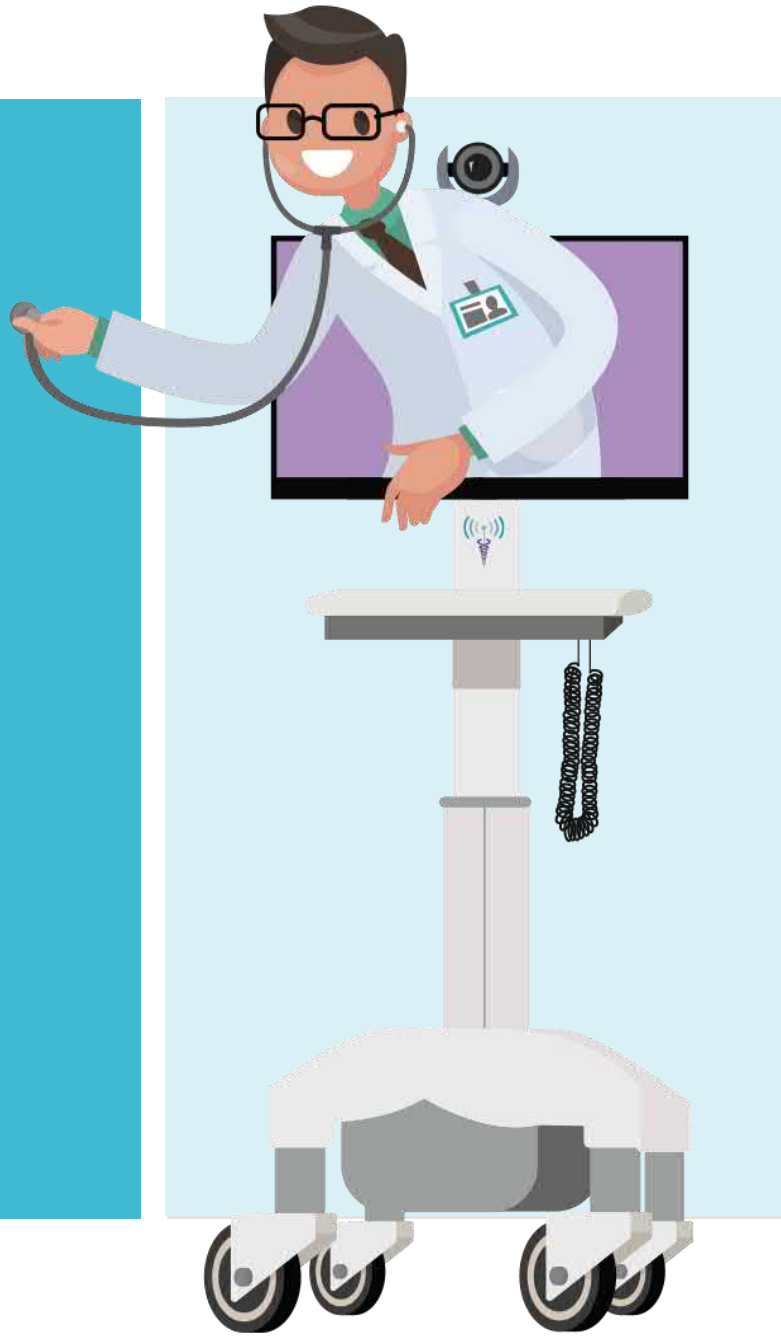
BEHAVIORAL HEALTH CENTERS

HOME HEALTH

HOSPITALS

CORRECTIONAL FACILITIES

DRUG INPATIENT REHAB CENTERS



Roll-Out and Adoption of TeleMedicine in Idaho:

Most important: Ensure immediate buy in from Medical Director, DONs, Clinicians, and staff

Facility IT support & Wi-Fi is up to date throughout the building

Onboarding with 100% attendance

Ensuring usage of the telemedicine program

Continued training for new hires

Bi-Directional communication with providers

Check the readmission data and compare a years worth of prior data vs the data produced after telemedicine is started.

Marketing Services that educate patients, residents and their families

Use goals TeleMedicine Must Meet to ensure location buy in.

Technology That Matches Care :

Portable Suitcase

Post Acute TeleMedicine Cart

Acute Care TeleMedicine Cart

Wellness Station

(ALF & Correctional Systems)

Identification of Technology is a must. In our use alone we have found that certain devices and certain peripherals are needed and not needed depending upon the care situation.

For Example Our Acute Carts come with 2 way Video and a stethescope only as additional tools are not needed in the environment where our post acute care cart additionally adds a Pulse Ox, Wireless EKG System, and additional modalities as needed.

Summary Conclusion:

TeleMedicine is proven to provide:

- Lower Readmissions to hospitals
- More care access to rural communities
- Increased care access during nocturnal hours.
- Savings on a financial level
- Multiple ways to start using and implementing a system
- Increased marketability in a senior care environment

Contact Information:

Waseem Ghannam
CEO of TeleHealth Solution
TeleMedicine Futurist and Influencer

1.(833) 633-3497

Ghannam@TeleHealthSolution.com

BIO

Neil Tantingco has over 20 years of experience in healthcare and technology. He founded Connected Home Living in 2015, and currently holds the CEO role where he grew the company as one of the leading Telehealth Turn-Key providers in the market, caring for remote patients in over 9 states.

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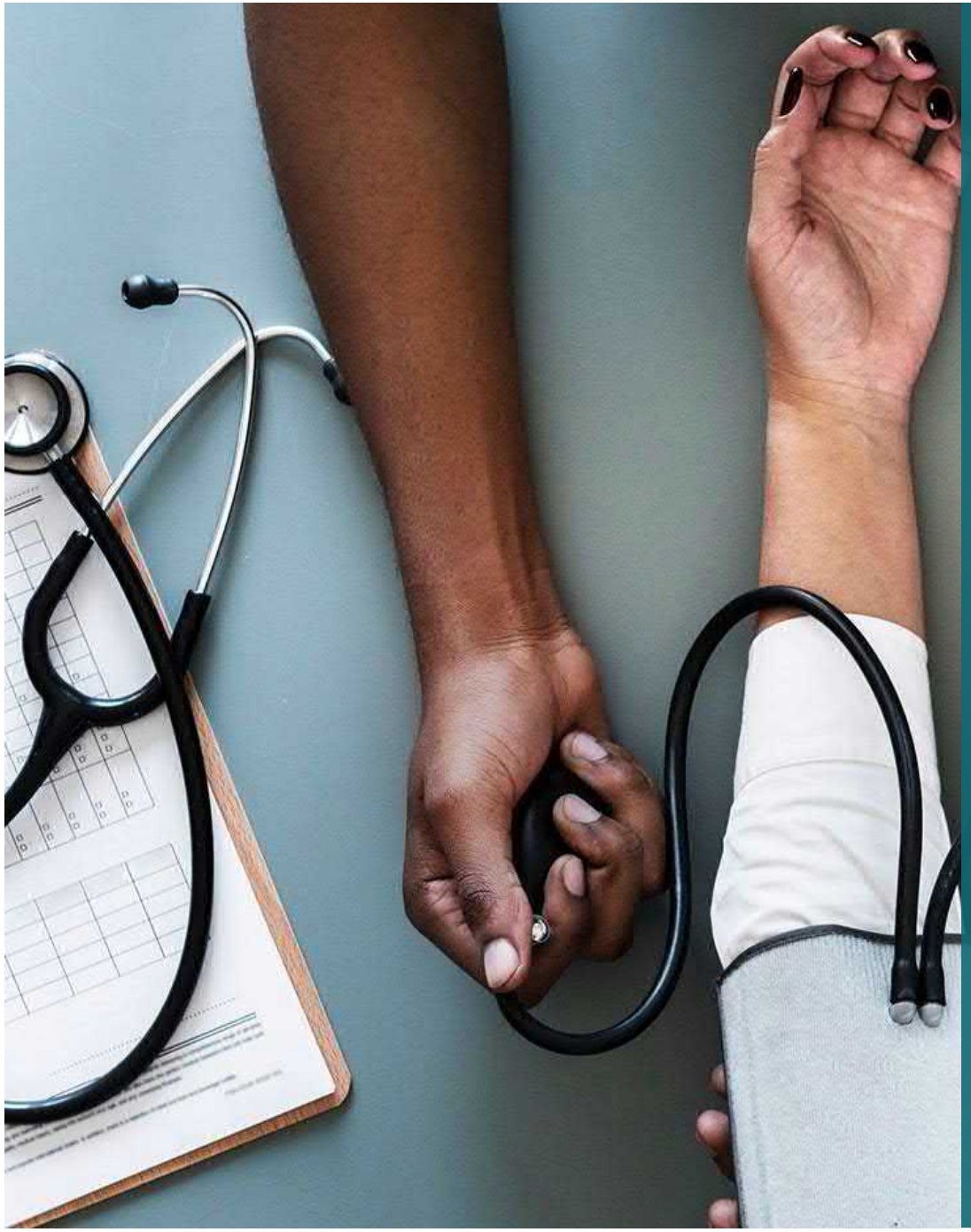


Remote Patient Monitoring
Presenter Name:
Neil Tantingco

Telehealth Task Force Subject Matter Presentation

April 29, 2020:

Connected Home Living:

Executive Summary of our Case Study:

Tech is only part of the solution. It's the people, stupid.

About Us:

Established 2015. Headquartered in Los Gatos, CA

Privately Held. Angel Funded

Customers

- Home Health & Hospice
- Hospital
- ACOs and IPAs
- Assisted Living & Private Clients

Average 200-250 daily patients across 9 States

Key Partners:

El Camino Hospital

Axxess (EMR) – Telehealth Partner of Choice for over 3,000 agencies

Wilshire Home Health & Hospice

CareOne Home Health & Hospice

Connected HOME LIVING

El Camino Hospital THE HOSPITAL OF SILICON VALLEY

AXXESS

Healthcare Tech OUTLOOK TOP 10 PATIENT MONITORING SOLUTION PROVIDERS - 2018

Connected Home Living

Connected Home Living (CHL) is a Turnkey Telehealth solution purposely built to prevent avoidable readmissions by blending live 24/7 professional Remote Care Coordination, with the latest intuitive remote patient monitoring, providing timely intervention, bridging external care services, and addressing patient psychosocial needs.

Remote Care Coordinators and Telehealth

- Constant Monitoring
  - Latest RPM (tablet/BYOD)
  - Proactive outreach
- Timely Intervention
  - Live 24/7 Remote Care Coordination
  - Video Triage/Picture
- Extension to Clinical and Care Professionals
  - Reminders
  - Follow Up Task in between visits
- Bridge Basic Social Determinants
  - Coordinate Transport
  - Assist with Pharmacy refill, Replenish Supplies
- Psycho-social Needs
  - Companion to Lonely and Isolated
  - Volunteer Group
- Close Loop Reporting
  - Proactive Reporting/Update to entire Care Team
  - On Demand Reporting via Portal

Coronavirus Telehealth Program

- Quarantine potential and infected Coronavirus patients at home
  - Avoid spread of virus thru Telehealth as suggestion by CDC
  - Isolate patients at home while providing access to clinicians via secured video conferencing
  - Limit ER and Hospital over utilization.
  - Capture data and share with CDC and Department of Public Health
- Screen and monitor Persons Under Investigation (PUIs) using:
  - HIPAA compliant Telehealth solution on smartphone, tablet or computer
  - Screen and monitor Persons Under Investigation via tailored health survey questions to identify red flags
  - Live video calling and ability to video conference multiple parties (physicians, specialist, family members)
  - Capture vitals and photos securely
  - Educational videos (pre-recorded and live)
- 24/7 Live Remote Care Coordinators, specially trained to monitor COVID-19
  - Constant monitoring and Proactive calls (up to several calls per day)
  - Respond to symptoms, vitals and inquiries then engage physicians and clinicians based on pre-defined protocols
  - Coordination of Social Determinants
    - Medication/Food/Equipment/Supply deliveries
    - Ensure completion of Specimen Collection (swab or blood drawn) to diagnostic center
    - Transport if needed
  - Provide Social Support and Reassurance to socially isolated patients

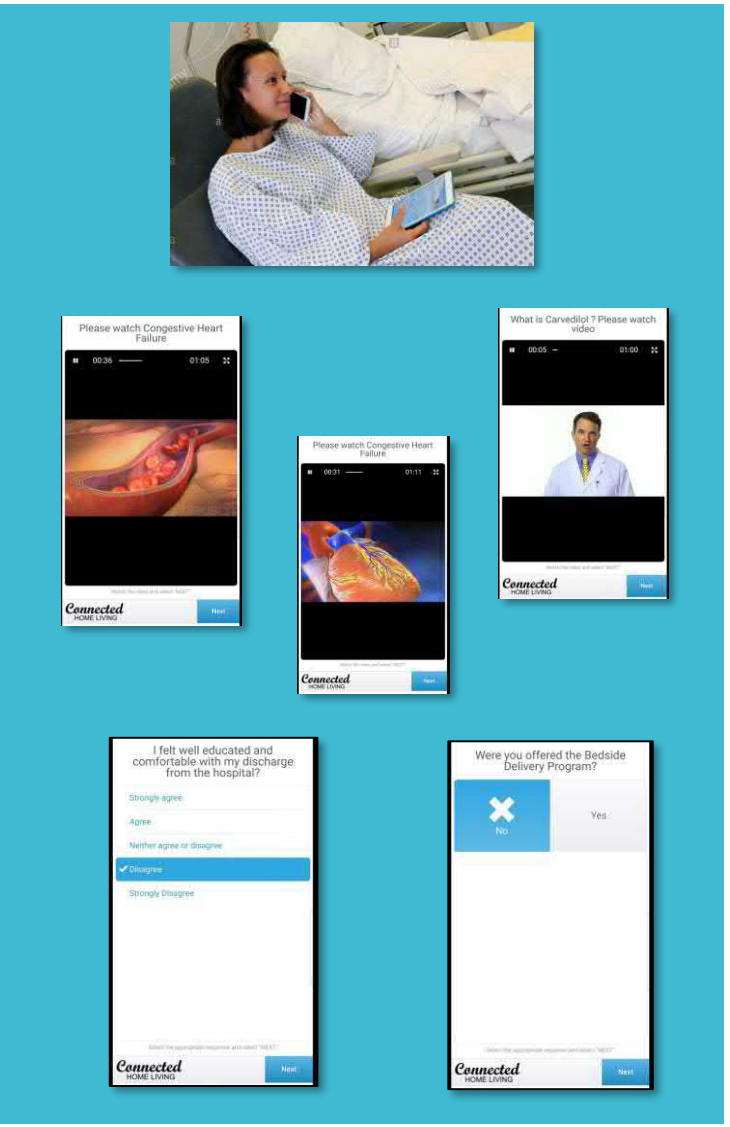
Hospital-To-Home Program

1.9 to 3.12%
Readmission Rate

- Home Bound Patients with No Home Health – Highest Risk of Readmission
  - Patients refuse Home Health
  - BPCI – 90 Days oversight
  - High Risk (CHF, COPD, PNM, Post-CABG, Post-Sepsis, etc.)
- CHL – Virtual Home Health provides:
  - Assigned 24/7 Remote Coordinators and Clinicians
  - Deploys and Set Up Telehealth Training
  - Constant Monitoring & Symptom Management
  - Telehealth Escalations managed by CHL Clinicians
  - Relays and Coordinates directly with PCP
  - Regular reporting to Hospital
- Readmission Rate = 3.12%
- Improved patient experience. Reduce avoidable readmission.

CHL Delivers the "Last Mile" – Imperative for Home Bound Patients with No Oversight

New Community Transition Program



- Transition Starts at Bedside
  - 3-5 days prior to discharge, refer to CHL authorized HHA
  - Supply Telehealth (tablet or BYOD) with Consent
  - Utilize idle time in bed to start Transition Program
  - Supplement discharge process with CHL
- Telehealth in bed
  - Educational videos (over 1600) – Illness, coping with ailment, medication
  - Preparedness
    - Medication training – bedside delivery if available
    - Equipment/Supplies
    - Transport
    - Secure Follow up appointment
  - Video Intro/Coordination by CHL Remote Care Coordinator
    - Reassurance – "Buddy" – available 24/7
    - Coordinate Community providers and even Families
- Patient Satisfaction
    - Obtain feedback before patient leaves premises
    - Provide opportunity to address/improve matters
- Post Discharge Monitoring starts from moment patient leaves SNF
- Improved patient experience. Reduce avoidable readmission.

New: Virtual Caregiving

Patient Benefit

- Promotes Aging and Healing at Home.
- Prolongs need for long term care facilities
- Low Cost. Highly Effective.
- Complements to Private Duty and Home Health
- Non-intrusive and Peace of Mind

	Wellness Care Plan	Safe Harbor Plan
Assigned Live 24/7 Remote Care Coordinator	✓	✓
Customized Care Plan & Reporting to authorized Family	✓	✓
Proactive Safety Check-ins and Reminders	1-2/week	3+/week
Chronic Care Management/COVID-19 Screening & Monitoring	✓	✓
Virtual Access to Board Certified RN/MD*	✓	✓

LOW COST. HIGHLY EFFECTIVE. AGING AND HEALING IN PLACE

CHL Affiliates

Add-On External care solutions available for CHL customers via remote virtual services

CORSTRATA

Wound Care Management Experts

MindCare®

Around the clock Mental Heath Services

PipelineRx

Tailored pharmacy and telepharmacy solutions

Errand Solutions
Luv Your Life

Personal Concierge services

MyPal 4 Life

PERS device with fall, motion and GPS detection

Teen Telehelp
Building stronger communities together

Volunteer Group

CHL Case Study – Frequent Flyer

Kristy would average 1 to 2 readmissions per week!

Kristy was non-compliant, with multiple chronic conditions and was lonely due to isolation.

CHL provides:

- Video check-in 2 – 3 times per day
- Adherence for RN instructions; e.g., cleaning trach, exercising, ordering supplies
- Assigned CHL Teen Volunteer

Case Study: Patient Kristy H - Frequent Flyer

Patient:

- 63 Year Old - Isolated & Depressed
- CHF-COPD + Munchausen Syndrome
- Tracheostomy + Morbidly Obese

Situation:

- 1-2 ED/Readmissions PER WEEK for past 18 months
- History of Non-Compliance
- No Social Outlet

CHL + St. Patrick + CMC + Sound Physicians In Action:

- Daily Social outreach by two RCCs via video calls
- Daily CHF-COPD Health Surveys - Timely Intervention
- Ongoing video call visits by TeenTelehelp volunteer
- Sit & Be Fit Exercise videos every 4th day
- Weekly Weight Measurement
- In-Home Care Attendant twice daily - Med Management

SUCCESS:

- 6 Months - 2 ED/READMISSIONS!!
- High Patient Satisfaction
- Weight decreased from 200 kg to 196 kg
- Reduced patient cost: Penalty & Length of Stay

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

Adjust Payment Model
Ease Regulations
Incentive Patients

Identify solutions to barriers

Summary Conclusion:

Telehealth More Mainstream – Post COVID-19

Regulations trending right direction
More innovative Remote Care Coming

Contact Information:

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CHL Website: www.connectedhomeliving.com
CHL Phone Number: 800.311-7859
CHL Email: info@connectedhomeliving.com

BIO

Madeline Russell is the Director of Quality at Lost Rivers Medical Center in Arco, Idaho. She participated in the Legal Studies, Healthcare Law Master's program from the University of Oklahoma and earned her Master of Business Administration degree from the Idaho State University College of Business. Madeline received her Bachelor of Science from Idaho State University in Health Care Administration.

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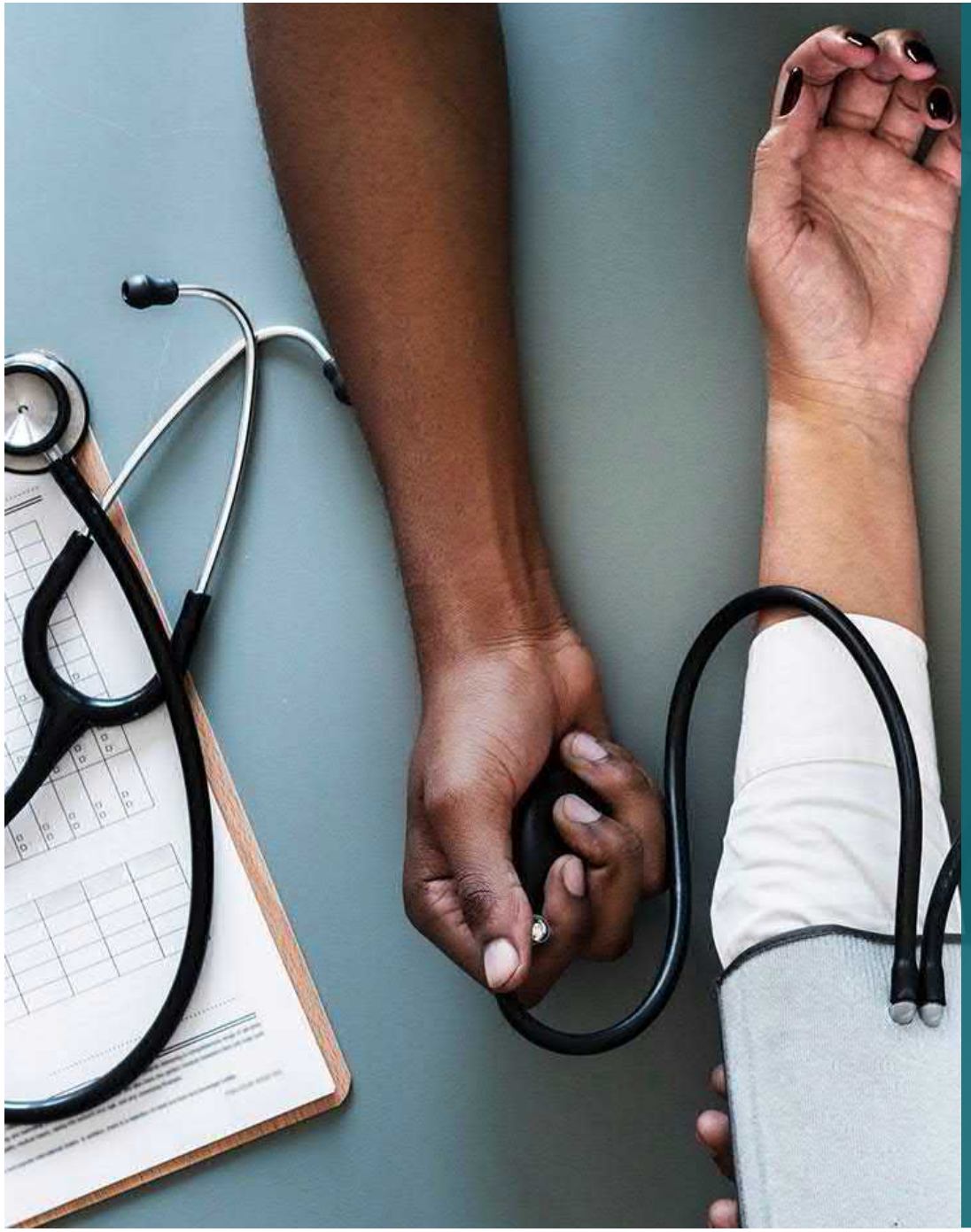

Madeline Russell:

Telehealth Task Force Subject Matter Presentation

April 29, 2020:

Lost Rivers Medical Center.

About Us:

Lost Rivers Medical Center is committed to meeting the health care needs of Idaho's Butte and lower Custer counties through compassionate patient care, excellent customer service and honest open communications. To fulfill this commitment, Lost Rivers Medical Center's board, employees and providers have dedicated themselves to continual quality improvement. Lost Rivers Medical Center is focused on teamwork, integrity, quality care, stewardship and service.

LOST RIVERS Medical Center

- Population 7,200
- Licensed Acute Beds: 14
- 2 Rural Health Clinics
- Surgery Suite
- Level 4 Trauma Center
- DNV accredited
- East Idaho Care Partners ACO

Executive Summary

- Lost Rivers Medical Center has been utilizing telemedicine in the Acute Care setting for many years. This was a requirements of our Level 4 trauma center status.
- Starting a tele-behavioral health program in our Rural Health Clinics.
  - Mackay and Arco both have Mental Health HPSA designation of 17
  - Nurse Practitioner finishing Psychiatric and Mental Health post-graduate certificate to provide services in the Lost Rivers valley
  - Implementation and go-live put on pause due to PHE
- Barriers include: no continuity across payers = confusion, physical examination is limited, patients hesitant of change, operational burden for adding a new service.

Magic Wand Scenario

"Telehealth is like government engineered a brand new highway for everyone to use – but didn't bother to paint on the center line, add the speed limit, or add rumble strips. So it's there to use, but without any of the normal guidelines we need to actual utilize it or feel safe."

- Continuity, parity, and easy to understand guidelines and policies throughout all payers would dramatically increase the usage of telehealth in Idaho. This can be accomplished by continuing to engage a multi-payer workgroup and having payers be more transparent (to patients and providers) on their telehealth policies.

Magic Wand Scenario

- Concerns from providers and patients that a virtual appointment does not seem adequate to diagnose or treat the patient.
  - Engage a provider telehealth champion that will be able to promote how effective virtual visits can be without a physical examination.
  - Educate patients on when to opt for virtual visit over in-person visit.
    - Community Health Workers are a great resource here
  - Coordinate, Coordinate, Coordinate!

Summary Conclusion

- Acquiring clear and easy to understand guidelines will help alleviate a lot of administrative and provider stress in utilizing telehealth.
- Important to train staff at all levels the benefits to patients, cost reimbursement, and ease of use to allow staff to make informed decisions when helping scheduling and seeing patients.
- Continue engaging with groups such as the Multi-Payer Workgroup and others to help meaningfully advance telehealth in Idaho.

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